

## **Mental Health Care, Diagnosis, and the Medicalization of Social Problems in Ukraine**

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This paper focuses on cultural issues associated with reforms of the mental health system in Ukraine. Specifically, the paper will explore the adoption of the International Classification of Diseases (ICD-10), with its heavy focus on biomedical definitions of health and illness, and the applicability of applying this model cross-culturally. Using first hand ethnographic data with psychiatrists, social workers and advocates, as well as patients or *'bolnoi'* (*bolnoi* translates literally as 'an ill person') of psychiatric services, I argue that 'mental illness' is not always, or solely, biological, but also culturally shaped, and therefore a 'one-size-fits-all' approach to mental health becomes problematic. I follow this argument with a discussion of how social problems more generally come to be redefined in Ukraine as medical in nature, where issues such as gender relations, alcoholism, poverty and environmental disasters are subject to medicalization. Here 'symptoms of oppression' or 'distress' are diagnosed within a psychiatric framework and become 'symptoms of illness', to be treated within the biomedical arena. This redefinition places the responsibility for larger societal issues on the individual and ignores the social and environmental underpinnings of suffering - a dynamic that was also operative in the Soviet system. I argue that the growing popularity of the medicalization of behavior coupled with its relationship with the pharmaceutical industry is thus a moral issue, and one with harmful results.

**Keywords:** medicalization; mental health; Ukraine; biomedicine; social problems; diagnosis

### **Introduction**

Before Ukraine's 'EuroMaidan' or the annexation of Crimea, Ukraine was in the midst of reforming its health care system, including its mental health care system. The country was, and I believe still is, moving away from a socialized, centralized system of care to privatized or insurance-based care. Other reforms specific to the mental health system include the

transition from ‘institutional’ to ‘community-based treatment,’ as well as the adoption of the International Classification of Diseases [ICD-10] - a diagnostic classification system from the global North and heavily influenced by psychiatry within the USA to diagnose and treat mental health disorders. While there is a push for community-based treatment, these types of outpatient centers do not exist. Instead mental health care is still found in the large state psychiatric hospitals, many built over a century ago. It is estimated that there are 87 of these state psychiatric hospitals in Ukraine, providing 47,000 beds (9.8 per 10,000 population) (Ougrin et. al. 2006).

Neoliberal rhetoric combined with the World Health Organization’s call for global mental health fuel reforms of the mental health system. The premise is that cutting social service expenditure through privatization and decentralization of the health care system (in addition to other areas) will stimulate economic growth. These political and economic reforms of the mental health care system in Ukraine are experienced as problematic, however, because they are forcing people to restructure their health seeking behaviors, and because they call into question people’s relationships to the state, community, and families, as well as morals, values, and identities. These reforms also include the Westernization of diagnostic criteria and diagnoses that encourage Ukrainians to frame mental health problems as biomedical in nature. Also known as medicalization, this process typically disregards environmental and societal forces acting on individuals and communities, shaping their life experiences within a model of health and illness.

Medicalization is not an entirely new concept to Ukraine as it was also used under Soviet rule to hospitalize dissidents in psychiatric institutions, as well as to conceptualize disability (Phillips, 2011), and childbirth and pregnancy (Rivkin-Fish, 2005). Today, however, medicalization in Ukraine is increasingly framed through ‘global mental health’ approaches and the discourse of human rights. Often these are used to combat the abuse of the ‘mentally ill’ or disabled (Patel et. al. 2012), which is widespread in many contexts, and certainly in Ukraine. The rationalization behind the Movement for Global Mental Health is to scale up psychiatric treatments through greater access to psychiatric drugs justified through the framing of distress as an illness. The relationship between Global Mental Health, psychiatry and pharmaceutical corporations is problematic for a number of reasons, many of which are associated with the profit-driven nature of these corporations. As Petryna and Kleinman (2006:20) write, ‘The Globalization of pharmaceuticals illustrates the sheer scale and complexity of our interconnected worlds...it is a multiscaled movement with political, economic and ethical dimensions... [which] constitute a ‘pharmaceutical nexus.’”

The Global Mental Health Movement, the use of human rights discourse, and the values associated with both ‘may have a liberating effect by creating new options for people limited by illness or untenable social situations, but it also creates ethical conundrums’ (Kirmayer, 2012:108). These ethical conundrums are rooted in the ‘global hegemony of psychiatric

knowledge' (Kirmayer 2012:108), most of which originates from notions of individualism and autonomy dominant in Europe and the USA, which are being exported around the world. In Ukraine, these ethical conundrums include dilemmas regarding the proper and humane diagnosis and treatment of the 'mentally ill', as well as the problematic nature of reforms when structural and ideological frameworks to make such reforms possible are missing.

Other dilemmas include the limitations of the biomedical model with regards to historical and intergenerational trauma. For example, in Ukraine, behavioral adaptations for coping and survival of such trauma may be considered 'symptoms' of 'mental illness' from a biomedical framework, and therefore force individuals to frame their experience as illness. Writing about the 'validity' of cross-cultural psychiatric diagnoses Kleinman (1988:12) notes that 'psychiatric diagnoses derive from categories... [which] underwrite the interpretation of phenomena which themselves are congeries of psychological, social, and biological processes... which are outcomes of historical development, cultural influence, and political negotiation.' This suggests that the mechanisms that enable people to cope with and survive oppressive regimes (whether they be colonialism, or for example, familial abuse) may come to be diagnosed, within a psychiatric framework, as symptoms of an illness – rather than 'symptoms' of oppression. This also supports the contention that political economies and power structures shape health and illness.

### *What's Ailing Ukraine? Diagnosing and Diagnoses*

In the diagnosis of 'mental illnesses' globally, a key debate revolves around the appropriateness of applying the Western biomedical model cross-culturally (Kleinman et al. 1988; Barber, 2001; Keyes, 1985; O'Neill, 1996; Kleinman, 1997; Young, 1995; Lock, 1982; and see White and Sashidharan in this volume). These arguments are perhaps even more pertinent when applied to societies where biomedicine is not widely used. In order for this argument to make sense in the case of postsocialist Ukraine, however, we must broaden the concept of biomedicine to include the Soviet health model. In other words, biomedicine does not belong exclusively to the West; however the resultant medicalization is still the same.

The limitations of the biomedical model for Ukraine can be best understood when considering the role that historical trauma (which plays a large part in Ukraine's history) plays in diagnoses such as Post Traumatic Stress Disorder (PTSD) (Whitbeck, et al. 2004; Lavi, et. al. 2005). For example, PTSD in the Diagnostic and Statistical Manual IV (DSM-IV) is described as a single traumatic event, while for many, trauma may be ongoing and intergenerational. As Young (1995) argues, traumatic memory is culturally shaped and therefore might not translate as a viable diagnosis in non-Western settings. In light of my argument however, 'non-Western' might not be the best word here as it does not include the Soviet model. Child development research (see Garbarino and Kostelny, 1996; and Hallis

and Slone 1999), has shown that, for children, exposure to persistent trauma may well not have the same effects as exposure to a single traumatic event. Indeed, habituation to traumatic events may be an adaptive response to chronic stress.

As Lindy and Lofton (2001:229) describe, in Eastern European contexts such as Ukraine, trauma and its reactions are 'typical of the sufferings of most if not all'; in other words traumatic experience has become normalized. Historical episodes, or politically generated stressors, such as war, ecological disasters and economic crisis, produce behavioral adaptations in individuals and families, such as 'caution, even paranoia, guilt and the inability to be free, dissimulation, splitting, self-discontinuity, intergenerational emptiness, and despair' (Lindy and Lofton 2001:xvi). Additionally, survival in an authoritarian context where documents were doctored, news withheld, and where those who complained were often condemned (Lindy and Lofton, 2001) required hiding one's feelings and making disclosure of personal issues difficult in a psychiatric context. These findings suggest that individual reactions to multiple traumas throughout Ukrainian history may represent coping mechanisms, or more specifically, learned responses to real threats.

This was evident in the conversations I had with Ukrainian psychiatrists, social workers, advocates and patients that I interviewed between June 2008 and February 2010 while conducting anthropological fieldwork. Most of my interviews were conducted at a large state-run psychiatric hospital in south-central Ukraine. Many interviewed understood psycho-somatic illness to be an ongoing manifestation of historical trauma (such as the forced famine of the 1930's, WWII, and Chernobyl), now exacerbated by current struggles such as the economic crisis of 2008. For example, the head of a psychiatric hospital when talking about PTSD said:

Well, you know everything depends on the situation; unfortunately we do not have a very fortunate situation. We do not have the stability that the country needs. And because of that you have all the Post Traumatic Stress situations happening, and don't forget we also have Chernobyl, that is still active, unfortunately. It also takes its toll on the flow of the psychiatric disorders.

The head of one of the woman's wards reworded my question regarding historical trauma, restating it in the following terms:

Oh you mean if the stress of this generation relates and influences the stresses in other generations...? If the level of stress is psychotic then yes it can, it's my own observation and even if it's at the neurotic level. In a way it does. But it all depends on the living conditions and the environment of the next generations. The war in some way has affected [individuals], the death of loved ones, single parent families.

While having a universal classification system for diagnosing illness may be desirable, because ‘mental illness’ is not always solely biological, but also culturally shaped, a ‘one-size-fits-all’ approach becomes problematic.

A few of the psychiatrists that I interviewed seemed to think that the ICD-10 is a better instrument than the ICD-9 (the diagnostic tool used up until 1991) but putting it into practice has not been easy. The head of a state-run psychiatric hospital felt that the ICD-10 is appropriate for Ukraine, but that any classifying manual does have drawbacks and the ICD-10 is not ideal. The head psychiatrist of a female ward, who has 45 years of experience and teaches at a medical university, still prefers the ICD-9 over the ICD-10. She says that for practical use the latter is not very helpful and that her lectures are taught using the ICD-9. She says that for her the ICD-10 is only useful as a reference. A disability specialist who is also a psychiatrist goes into more detail regarding the applicability of the ICD-10. He feels it is better than the diagnostic tools available during the Soviet Union, which he describes as being based on a ‘nosologic approach.’ This type of approach is etiological, meaning it is based on the cause of the illness as opposed to the Western approach, reflected in the ICD-10, which is based on ‘symptoms.’ He says the switch to the ICD-10 has been the most difficult for older doctors; however he feels that symptom-based diagnosis is better in the long run for patients, especially since ‘cause’ is not always known.

The emphasis on cause as opposed to symptoms might be based in cultural and ideological values specific to the Soviet Union. Phillips (2011:54) writes that pain, suffering and disability during the Soviet period had to be presented in the framework of dialectical materialism, and that war related mental trauma was understood as existing in the sufferer’s body and physiologically (medically) based. She says this male-centric (and I would argue biological) nature of Soviet understandings of disability did not include women or children until *perestroika* (restructuring policy initiated by Mikhail Gorbachev) since they did not fit the Soviet political-aesthetic project which favored war and work (Phillips, 2011:57). This way of conceptualizing disability also seems to suggest that there was a political dimension to causes and symptoms, and to decisions about what counted as a ‘cause’ or ‘symptom’.

Another difference between Soviet and Western approaches to diagnosis, as identified by a disability specialist I interviewed, lies in the ‘permeable’ nature of diagnosis. For example, if a person has at least one symptom of schizophrenia then, under the Soviet system, one could be diagnosed as ‘a little schizophrenic,’ but according to the Western approach this diagnosis is mutually exclusive; you are either schizophrenic or you are not. The Soviet approach can be traced to the prestigious Moscow School of Psychiatry and to A. Snezhnevskii, who understood that ‘people suffering from mental illness exhibit different psychotic syndromes which fall on some point of a band or spectrum of pathology’ (Miller, 1986:19). This spectrum concept allowed for varying degrees of illness and is helpful in understanding how doctors were able to label political dissidents as schizophrenic. Thus, psychiatry during

Soviet times functioned as a powerful tool of social control that ensured the survival of the system by discrediting, ‘getting rid of’ or ‘taking care of’, anyone that opposed the regime.

### *Authoritarianism and Social Suffering*

Entangled with neoliberal political and economic structural reforms and the associated cultural tensions identified earlier, as well as diagnoses and treatment of mental health issues, are ideologies which shape definitions of ‘normal’ and ‘abnormal’ behavior. For example, in the interviews I carried out with ‘*bolnoi*’ (meaning sick or ill person, which when translated into English resembles the word ‘patient’, however problematic) it is evident how the social effects of living under an authoritarian regime for decades have shaped the texture of everyday life. This history includes dramatic crises such as famine, war and nuclear disaster. But just as important are the everyday experiences of living under an authoritarian regime, such as social mistrust, the disintegration of families, displacement, detention, and the use of psychiatric hospitals for repressing dissidents. Living in such an environment leads individuals and families to develop behavioral adaptations necessary for survival (as mentioned earlier), such as, paranoia and guilt, splitting and despair, to name a few (Lindy and Lifton, 2001). These behavioral adaptations were useful for survival under Soviet rule, but may now ‘contribute to difficulty in adapting to the changes after the break-up of the Soviet Union’ (Lindy and Lifton, 2001:18). Additionally, according to the ICD-10, these traits are considered symptoms of ‘mental illnesses’.

Take for example, the famine of 1932-1933, officially acknowledged by Ukraine as an act of genocide towards the Ukrainian population by the Soviet Union in 1991 (Chopivsky, 2011). The events that led up to the famine included rapid industrialization and collectivization. Collectivization meant that farmers had to give up their lands to work together on communal farms. Ukraine would be responsible for growing food to supply to the rest of the Soviet Union. Ukrainian peasants did not give up their lands without a fight; rather, they slaughtered their livestock, burned their fields, protested with armed insurrections, or moved to cities as forms of resistance (Magocsi, 2010; Subtelny, 2009). The wealthier peasants who resisted collectivization, called *kulaks*, were labeled ‘enemies of the people, and presented as wealthy land-grabbing exploiters of their fellow villagers’ (Magocsi, 2010:594). Those labeled as kulaks were eventually rounded up and shipped to Central Asia, Siberia, and the Soviet Far East, and by 1930, nearly 62,000 kulak households had been eliminated (Magocsi, 2010).

In 1932, a law was put into place where anyone caught ‘taking anything from the collectives - even an ear of wheat or the broken root of a sugar beet – could and often did result in confiscation of property, a ten-year prison term, and even execution’ (Magocsi, 2010: 600). While at the same time, famine had already started spreading (Subtelny, 2009). The exact causes of the famine of 1933 are often contested, however, there is agreement that ‘several

million deaths did occur in Soviet Ukraine during the Great Famine of 1933' (Magocsi, 2010:600). While most people who were alive at the time have since died, every year the famine is remembered through the media and with public memorials and marches. The former President of Ukraine, Viktor Yushchenko, made it a political goal to have the *Holodomor* (Ukrainian term to refer to the famine of 1932-1933, meaning 'extermination by hunger') recognized outside of Ukraine, and particularly in Russia, as genocide.

Because of the 1932-1933 famine (there were other less publicly remembered famines that took place in the 1940s), food and food scarcity are embedded within historical memory in Ukraine. One elderly woman that I interviewed, who, in 1932 was eight years old and lived in an urban setting, said she does not remember much about the famine, but does remember neighbors starving; she recalled a particular family to whom people would give food. Her son, who was also present during the interview, told me afterwards that he has known many people who continue today to hide food around the house in socks 'just in case.' One patient directly links her illness (she says she has been diagnosed with schizophrenia, although she says she does not hear voices and she does not suffer from depression) to her mother's and grandmother's experiences in the famine of the 1930's, and says she has passed on the 'sickness' to her children as well. She said that she 'inherited it from her mother' who inherited it from her grandmother. However, she was unable to describe the 'sickness,' stating that it has been passed down by the women in her family.

Many people that I interviewed said that they believe the famine was not just in Ukraine, but all over the Soviet Union – that Ukraine was not specifically targeted. Regardless of how the famine is conceptualized however, most do agree that many people died in Ukraine. The difficulty for many that I interviewed is the knowledge that the families that survived were probably implicated in carrying out the 'disastrous agricultural policies' that contributed to the famine. In other words many of the events leading up to the famine and the deaths of so many, while originating from outside of Ukraine, were carried out by Ukrainians. This impact of the famine is rarely considered in the Ukrainian media. One of my interviewees, a disability specialist and psychiatrist, summed up two kinds of trauma that he sees as resulting from the famine: trauma from knowing the horrors that took place, and the trauma of surviving those horrors. He says:

Well, let's start from 1933. In 1933 a lot of people died, we know that for a fact. But the ones that died they are quiet; they will never say anything at all. The ones that died didn't have any children, he goes into the ground, that's it and you cover him up. The ones that have survived from 1933 they were always told, just like my parents told me - and that is where you are right - it was a mental trauma for the very little ones and we all know that very well. But in Ukraine there were not only those that died from the famine, in Ukraine there were also those that were creating the famine. Our people. They did give birth to children; they gave them education and so on.

These people have a different kind of trauma because they understand completely that a horrible thing has been done, but there are more of those people. And they would not allow the other ones [survivors of famine] to tell this truth. So, here you have two kinds of traumas. So, some people want to tell the truth and others do not want the truth to come out. Nobody wants to have a grandpa that did such bad things. As my grandfather said, who was also a famine survivor, he said, in my house 'I did not have Stalin, Molotov, or Kaganovich, I had neighbors.' The famine was done by its own people. Our own people were making it.'

His story highlights how shame and mistrust entered into intimate relationships because those who carried out policies that made the famine possible were not outsiders, but neighbors. This is exemplary of authoritarian tactics which pit different sectors of the population against one another, engendering mistrust.

### **Collective Suffering and 'The Great Patriotic War'**

While I was very interested in the effects of the famine on the Ukrainian people, it was often the memory of 'World War II' or 'The Great Patriotic War', as it is known in Ukraine, that seemed more on the minds of the people who I interviewed. Just about everyone I interviewed had a story to tell about the Great Patriotic War. Natasha, the secretary for the NGO Human Rights for Psychiatric Patients HRPP not only survived the War, but was also 'repressed' (sent to gulag). She described the events to me:

During the War I was in Kazakhstan. I was sent off because my father was repressed in 1938. The thing is that my father was the head engineer at a chemical factory and my mom was following him around. He was considered an enemy of the state. [In Kazakhstan] we used to go to the field and pick frozen potatoes. We would pick wheat. And back then for wheat grains you would get 5 years in prison. If you have collected some wheat and you were caught, then you would get 5 years. My mother, while we were gathering frozen potatoes, was seen by the watchman and was beat up so bad that she couldn't get out of bed for three months.

She then goes on to describe the conditions that her family lived in and the traumatic experience of war.

When we were leaving Novorossiysk...the whole city was burning and there was a railroad that was going between two mountains and that is where they would bring out the wounded and the German fighter planes would fly over and kill the wounded. And we would drop everything and start retreating... Germans would fly by again and shoot again. They would start shooting and everybody would drop everything and run

to hiding places if it was possible. My grandmother always covered me up with her whole body. There was a lot - there were bodies and everything else was out there.

Natasha's story highlights the trauma of war and how it was experienced by a young child. Her stories speak of repression, social fragmentation and political suspicion. Behind her descriptions of the trauma she suffered there is an underlying theme of resilience, heroism, perseverance and determination. These were common themes that accompanied the stories I was told of WWII.

Ukrainians that served in the war are proud of their achievements and while they often look on the war as terrible, it also marks a time of great pride. It is because of this that I believe the Great Patriotic War was probably the most collectively significant event in the lives of Ukrainians and continues to shape lives today, especially regarding ideology, such as issues of morality, justice, and right and wrong. Many survivors of the Great Patriotic War (WWII) are still alive, meaning there is a living memory. However, the numbers of survivors of the war are decreasing. I personally witnessed a number of funeral processions for survivors of the War, where the deceased is carried down the street in their coffin on the shoulders of men, with family members, friends, and a small band of musicians (usually trumpets, trombones, or tubas) playing sad, long tones, following behind. In this sense people are reminded weekly, if not daily, of the passing of war veterans. A General I interviewed recounted:

I am in the Army since 1939, but in our schools, where I went to there was huge patriotism, we loved our country so much that we were ready to go and fight without asking questions. And only thanks to such patriotism we beat the Germans. At the time the German Army was the strongest Army in the world. And you see, in 1941 we were retreating, in 1942 we were retreating, but then we gathered together thanks to the Soviet power, you see it was all centralized. And that is why we defeated such a strong opponent.'

His statement speaks of determination and resilience, and while he was not disabled, does seem to support Phillips (2011:56) findings that the model for the 'New Soviet Man' after WWII was one that could not be represented as 'different' but as 'overcoming' (their pain or disability). Such repercussions from the war that continue to shape people's lives are also evident in the experience of a businesswoman who was about to be released from the psychiatric hospital. She recounted in an interview how difficult her and her father's lives were because her father was a German living in Ukraine. She described the impact that this had on her growing up:

You know because my father was German, his whole life he has been followed and questioned, tortured; they would not let him work, express himself. So he killed

himself. Since then I have realized that I am not like everyone else. I was nineteen. He jumped out of the fifth floor, right in front of my eyes. In one minute my hair turned grey.

It was these experiences, resulting directly from WWII, and further compounded by the economic crisis of 2008, that she attributes to her difficulty in Ukrainian society, her mental health issues and attempts at suicide. She described how before the economic crisis of 2008 she was actually doing quite well, she owned a:

pharmacy, a grocery store and I was building a 48 units apartment complex. Now I will not be doing so great, the dollar exchange rate went up 2 times against the *hryvnia*. Nothing good...now since the crisis it will all go to the banks for the debts.

Here we can see how transitions in mental health care interlace with memories, and economic and historical dynamics: she had a breakdown and was admitted against her will by her family into the psychiatric hospital. However, while she says she did suffer in the past from society's response to her father's nationality and suicide, she had managed to do quite well after the independence of Ukraine by taking loans and investing in businesses. She was not in the hospital because of her father's suicide necessarily, but because of the relapse brought on by economic despair.

### **Economic and Individual Crisis**

Ukraine's economic decline after independence, as well as the economic crisis of 2008, was and continues to be devastating for others as well. The loss of the social safety net provided by the Soviet Union for salaries, pensions, housing, and so forth made this economic decline doubly worse (Phillips, 2005; Rivkin-Fish, 2011). The numbers do not really tell the story. I was able to interview a retired General, a veteran of the Great Patriotic War, who was deeply disturbed by the changes he was seeing. Speaking generally for all veterans he described how changes after Ukraine's independence, in particular market reforms, were affecting the lives of everyone in Ukraine through low wages and inadequate pensions. He says:

The pensions and the salaries are very low... miners... teachers... doctors... people of the culture sphere [theater workers and such] have very low salaries and very low pensions for those that have disability. The minimum pension is 550 hryvnas [in May of 2008 the hryvna was 4.60 against the dollar, or \$119.00, and in January of 2009 it was 8.80 against the dollar, or \$62.00]. And now we have no war, the harvest is good, but still people are hungry. People are so electrified; there is a lot of unhappiness among people, negative attitudes toward the government. So, one big question that is scaring us right now is that there will be unemployment. So, you tell

me, a young man not working, he has to live. A lot of criminals can start appearing [because of unemployment]. They will be stealing because somehow they have to live; it is a very dangerous story.

What connects these individual and collective histories is how the social environment, as well as the political economy plays a role in mental health and vice versa. Social suffering, no matter its origin - war, disaster, poverty, or politics - is always imbued with culturally specific meanings. Shouldn't treatment and healing for symptoms arising out of such histories also be culturally specific? As Kleinman (1988:10) says, 'by medicalizing [suffering] we deny the existence of social problems, or the darker side of major social transformations', a process that is arguably carried out by biomedical psychiatry. As Kleinman (1988:3) puts it, 'Mental illnesses' are real; but like other forms of the real world they are the outcome of the creation of experience by physical stuff interacting with symbolic meanings.' This means that the reform of the mental health system in Ukraine is not just about structural reorganization but also about cultural reorganization. This process of medicalization disregards environmental and societal forces acting on individuals and communities. Moreover, medicalization, or the pathologisation of behavior, is carried over into all areas of culture. This is an issue I will further explore in the next section, where I will discuss how social problems arising from political-economic changes due to neoliberal reforms are also being addressed as behavioral issues, i.e. they are medicalized, and therefore constructed as being 'treatable' in the context of the mental health system.

### *Social Problems and the Link to Neoliberalism*

The transition to capitalism and a (global) market economy is registering culturally in many areas, such as gender, poverty, and environmental disasters. The impact of these transitions on culture in Ukraine are manifesting into new social problems. For example, one of the youngest patients that I interviewed, a 19 year old male who self-identifies as having a diagnosis of schizophrenia and whose mother was also currently hospitalized with schizophrenia, felt that there were many people in the hospital who shouldn't be there. He stated that many people hospitalized for 'mental illness' are only there because of financial reasons or because their families put them there - in other words they themselves and/or their families are too poor to take care of them. Whether their 'mental illness' is real or a survival tactic, living at a psychiatric hospital seems like it would be a measure of last resort, which supports the idea that there is a trend towards medicalizing social problems, such as poverty and homelessness. I am not trying to say that people are faking 'mental illness' to get help in a psychiatric hospital, however, because of the loss of safety nets previously supplied by the state, many people are desperate and have nowhere to go.

This is similar to what Kleinman (1988) discusses with regards to the North American

disability system, where social problems such as poverty, unemployment and so forth are treated as medical problems and hence medicalized. He says this acts as a way to re-distribute income, something that U.S. society would not expressly authorize outside of the health care system. The result is much needed help in the form of income from social security (although arguably inadequate) for those who qualify. However the underlying causes of social inequalities remain unaddressed.

In addition to, and coupled with, issues of poverty, the transition to a (global) market economy registers in the link between environment and health. While I did not interview anyone directly affected by Chernobyl or anyone who believes their illness is a result of radiation exposure from the meltdown, I did meet a family whose health problems are possibly linked to exposure from a nearby nuclear missile silo. Approximately two miles from their home, where they grow all their own food, sit five silos which until very recently housed nuclear missiles. The missiles were given back to Russia and the site was declassified in the late 1980s. Once the missiles were removed however, the silos were flooded with water. The mother of this family suffers from severe epileptic episodes and their son, who was born healthy, suffers from epilepsy as well as other disorders that kept him in a wheelchair until recently. He is also currently having problems because his brain is growing but his skull is not. In the interview with this family they described their problems in terms of the biomedical model, but also felt that it could have been the 'evil eye,' or *porcha* (cursed). Later in the interview, the empty nuclear silos were casually brought up as a possible cause. While this has not officially been labeled as a 'disaster' or even acknowledged as an environmental issue, the families that live near this site have to live with the uncertainty of their own exposure to nuclear waste and its impact on their health. This uncertainty as to the causes of their illnesses creates tremendous stress. Here their inability to work - poverty and health issues possibly caused by environmental toxins - are explained as biological in nature and originating within their bodies, and hence medicalized. In addition to being medicalized, the attribution of disease or illness to nuclear toxins is also a politicized issue, especially in regards to nuclear disasters such as Chernobyl (Petryna, 2002), or the Bhopal disaster in India (Fortun, 2001). A final example of the way the transition to capitalism and a (global) market economy registers on a cultural level can be found in the link between alcoholism and historical trauma.

### **Alcoholism and Historical Trauma**

Alcoholism is an interesting domain richly infused with cultural meanings that are not understood very well using only clinical explanations. The director of the psychiatric hospital, whom I interviewed, discussed the exceedingly high rates of alcoholism in Ukraine. He believes that 'because Ukraine produces so much beet sugar there has always been a lot of home brewing' and notes that 'children that were conceived while drinking ... have more

pathologies than children with no alcohol.’ While I did interview several patients who were in rehabilitation for alcoholism, this was usually coupled with other diagnoses, such as schizophrenia or depression. I believe several factors are at play here for all of these diagnoses; one of these is historical trauma.

Alcoholism in Ukraine is a widespread problem, both for the country and the psychiatric hospitals within it. In 2002, the World Health Organization (WHO) administered the first structured psychiatric interviews in Ukraine to assess the prevalence rates of nine psychiatric and alcohol disorders. Their results indicated that close to one-third of the population experienced at least one DSM-IV disorder in their lifetime. In men, the most common diagnosis were alcohol disorders (26.5% lifetime) and mood disorders (9.7% lifetime); in women they were mood disorders (20.8% lifetime) and anxiety disorders (7.9% lifetime)’ (World Mental Health Survey, 2005). The WHO Mental Health Global Action Programme or ‘mhGAP’ initiative subsumes alcohol disorders, along with many other issues, under the category of ‘neuropsychiatric’ disorders (WHO, 2008).

My own observations lead me to believe that alcoholism is a socially induced behavioral manifestation of distress – a socially sanctioned activity with deep cultural roots – further promoted by poverty, not to mention a socially-acceptable vehicle for men to talk about their problems. As Wanner and Dudwick wrote ‘vodka has enormous symbolic and practical importance in the culture and everyday lives of Ukrainians... In rural areas, homebrew *samogon* is so readily accepted as payment in a multitude of transactions that it is referred to as a ‘freely convertible currency’ (2003:267). They further point out that after 1986, ‘food prices in Ukraine soared, while alcohol remained affordable’ (Ibid:267). Additionally, alcohol consumption can be viewed as enabling men to express emotion in a gender ‘appropriate’ manner, rather than appearing to complain or show stress - behaviors or expressions that would otherwise meet with social disapproval if displayed in the context of sobriety. For women however, alcoholism is viewed more harshly. For example Murney (2009:ii) writes that women addicts are seen as ‘consciously abandoning their femininity, their families and their nation,’ which means that they often do not seek treatment. While the abuse of alcohol can be seen as someone having an ‘escapist attitude’ (Riabchuck, 2012:215), I feel that a more fruitful understanding of alcoholism in Ukraine should recognize the influence of the structural – the social, political and environmental underpinnings of suffering, just as Riabchuk (2012) concludes for homelessness. For example, Riabchuck (2012:209), writing about a ‘crisis of masculinity’ in Ukraine, feels that the transition to capitalism may not have caused the crisis, but it has affected the economic and psychological well-being of men, and that these are linked to social problems such as alcoholism and homelessness. She states that in Ukraine ‘de-proletarianization, unemployment, and lack of social security during a transition to capitalism are the main causes of poverty, alcohol abuse, crime and deviance’ (Riabchuck, 2012:206), which together have contributed to extremely high numbers of homeless men. Many of these individuals eventually end up in the psychiatric hospital at

some point.

Riabchuck (2012:208-209) describes this crisis as being further compounded by difficulties in the labor market where traditionally male-dominated sectors of the economy have shrunk, such as the military or machine building, and where available work is now found mostly in service sector jobs where women are more welcome as employees. Here alcoholism is a symptom of larger societal issues; however by conceptualizing it as a medical problem we ignore the underlying issues, such as unemployment and the feminization of labor.

### **Medicalization as Social Control**

Kleinman (1988) describes medicalization as an alternative form of social control, where medical institutions replace legal, religious and other community institutions as the arbiters of behavior. However, the medicalization of behavior, health, and social problems disregards environmental and societal forces acting on individuals and communities and transforms these into individual problems requiring medical control (Baer et al. 2003). In other words, medicalization transforms *victims* into individuals with a disease, denying causes that are linked to, or complicit with, larger societal forces, such as the restructuring of the economy, loss of safety nets, and so forth. Again, this is not particular to the West, as medicalization was also used in the Soviet model of health care. Recent political economic reforms are being touted as a way to restructure the economy so as to bring about positive change, yet my findings suggest that such reforms will continue to exacerbate tensions already present in postsocialist Ukraine.

The Global Mental Health Movement states that there is a commitment ‘to improving the availability, access and quality of services for people with mental disorders worldwide’ (see [www.globalmentalhealth.org](http://www.globalmentalhealth.org)). On the outset these are goals that I think most would agree are needed. However, as I have shown through my anthropological research with psychiatric patients and practitioners, the kind of changes associated with these goals in Ukraine through the reforms of the mental health system, are being experienced as problematic. One side effect of globalizing mental health is that we end up limiting our definition of ‘mental illness’ to physical disorders of the brain to be treated with medication. Getting sick however does not happen in a vacuum – health is greatly impacted by a myriad of factors; political, economic, cultural, environmental, and biological. Changes in societies, such as the adoption of socialism in the Soviet Union, to the current promotion of capitalism and neoliberalism globally, influence and change health. Political-economic forces, thus, shape who gets sick, why they get sick, what they get sick with, and what treatment is available.

I argue that defining not only distress, but also social problems such as gender relations, alcoholism, poverty and environmental disasters, in terms of medicalized discourses, results

in placing the responsibility for larger societal issues on the individual and ignores social and environmental underpinnings of suffering - a dynamic which ironically was also operative in the Soviet system. If it is the goal to improve availability, access and quality of mental health services, then I argue that medicalization is not the answer. Would it not make more sense to envision a 'moral economy' in order to mitigate the negative effects of neoliberalism? There have been suggestions that the 'free market,' instead of promoting 'profit-driven health,' should promote 'value-driven health' (Brezis, et al. 2011:232). McGregor (2001:88) calls this a 'people-first philosophy,' which has the intended goal of keeping society from becoming an appendage of the economy, meaning that the rights of people come before the rights of capital. This is because corporate-controlled markets, along with the excesses of capitalism, pose grave challenges to social justice and the public, as well as to health and health care (Brezis, et al. 2011).

Thus, an important question to ask is - how do we mitigate the growing popularity of the medicalisation of behavior and its connection with corporate capitalism, especially expressed in psychiatry's relationship to the pharmaceutical industry? Kirmayer (2012:108) writes that 'psychiatry must see beyond its complicity with the pharmaceutical industry and other economic and political interests that encourage mental health professionals and patients to frame problems in ways that exclude the social origins of suffering' (ibid, 2012:108). Health and healing, and the institutions such as psychiatry, that shape them, are thus, only as moral as the political-economy that binds them.

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